PERSON CENTERED PLANNING GUIDELINES

BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES

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Person Centered Planning Guidelines

These Person Centered Planning (PCP) process guidelines are intended to assist the focus person (i.e., the person receiving the services), their family members and friends, service coordinators/case managers, and state and local service providers who participate in life planning. The purpose of this document is to guide the team in making the choices and developing strategies that comprise the support plan based on the focus person's desired lifestyle rather than the traditional remediation and deficit approach.

The person centered planning process is a core component of quality service delivery. Person centered planning should not be viewed as an "add-on" to the current planning process. Instead, person centered planning replaces the deficit-based assessment that traditionally has driven the Individualized Service Plan.

The focus person is the central driving force in determining his or her future vision, goals, supports and services. The planning process requires family members, friends, and professionals to listen to the focus person; attend to the details; to be open and sensitive to situations that can be difficult and confusing; encourage dreams and desires of the focus person and contribute; and to identify and support what really matters to the person. The person centered planning process requires a shift in traditional thinking, actions, and way of doing business. The focus person directs the services and supports.

I. Definition of Person Centered Planning

Person centered planning is a process whereby persons with disabilities, with the support of families, direct the planning and allocation of resources to meet their own life vision and goals. This planning process:

- Should be based on a person's preferences, dreams, and needs;
- Understands how a person makes decisions;
- Understands how a person is and can be productive;
- Discovers what the person loves and dislikes;
- Encourages and supports long-term hopes and dreams;
- Is supported by a short-term support plan that is based on reasonable costs given the person's support needs;
- Includes the focus person's responsibilities;
- Includes a range of supports including funded, community and natural supports; and
- Should be conducted at least annually.

II. Terminology

1. *Discovery process*: the process of identifying the strengths, preferences, and desires of a focus person. It is an information gathering process that provides the foundation for developing/updating an individualized support plan. This occurs on an ongoing basis.

2. *Facilitator*: the individual who ensures the proficient development of a person centered plan. This individual is anyone chosen by the focus person. The facilitator gets people to share ideas and efficiently leads them through the process. He or she involves the focus person and assures understanding of the discussion. The facilitator must be a good listener, check understanding regularly, observe themes, and guard against immediate or old solutions. He or she prepares for the meeting(s), maintains focus and redirects concerns unrelated to the plan development.

3. *Focus person*: a person with a disability seeking or receiving services.

4. *Informed Choice*: the ability to make a voluntary decision based upon options presented to the individual.

5. *LAR (legally authorized representative*): is a person authorized by law to act on behalf of a focus person and who may include a parent or guardian of a child, or a guardian of an adult.

6. *Natural Supports*: supports that occur naturally within the focus person's environment. These are not paid supports or those purposely developed by a person or system. Natural supports should be utilized and enhanced whenever possible. Purchased services should supplement, not supplant, the natural supports. Some examples of natural supports are the family members, church, neighbors, and friends.

7. *Open-ended questions*: questions that do not suggest an answer, e.g. not simply yes/no or multiple choice questions.

8. *Person Centered Planning Team*: the team established by the focus person that typically includes his/her legally authorized representative (if applicable), close family members/advocates, the case manager, providers, a BDDS Service Coordinator and other identified by the individual as being important in his/her life.

7. *Service Coordinator/ Case Manager*: an individual employed by or contracted by FSSA who provides assistance to the focus person in identifying and accessing medical, social, residential, employment, educational, and other appropriate services that will help a focus person achieve a quality of life and community participation acceptable to the focus person (and LAR on the focus person's behalf) as follows:

    a) crisis prevention and management-locating and coordinating services and supports to prevent or manage a crisis;
    b) monitoring-ensuring that the focus person receives needed services; evaluating the effectiveness and adequacy of services, and determining if identified outcomes are meeting the focus person's needs and desires as indicated by the focus person (and LAR on the focus person's behalf).

c) assessment-identifying the nature of the presenting problem and the service and support needs of the focus person; and
d) service planning and coordination-identifying, arranging, advocating, collaborating with other agencies, and linking for the delivery of outcome - focused services and supports that address the focus person's needs and desires as indicated by the focus person (and the LAR on the focus person's behalf).

III. Guiding Principles for Person Centered Planning

Person centered planning is based on a variety of approaches or “tools” to organize and guide community change and life planning with people with disabilities, their families and friends. All approaches or “tools” have distinct practices, but share common beliefs. Although FSSA does not require the use of a specific “tool”, the elements listed below must be evident in the planning process.

1. Person centered planning process is based on a framework that describes five essential accomplishments: 1) community presence, 2) community participation, 3) choice, 4) respect, and 5) competence.

2. Individual differences and differences in family dynamics and composition are respected and accepted.

3. Person centered planning requires that it is the focus person who defines what is meaningful in his/her life and what really matters most to him/her.

4. All focus persons have the opportunity to make informed choices and need to exercise control of their lives. Sometimes in order to do this effectively they must be supported by others, either in their natural environment or from within the system.

5. The focus person must have choice among flexible, dependable services that meet their immediate needs and support their goals and aspirations for a lifestyle that affords personal control, informed decisions, dignity and respect.

6. Person centered planning builds on a focus person's strengths, gifts, skills, talents, and contributions.

7. Person centered planing processes encourage the "building of community" around focus persons. They help develop supports to facilitate relationships with people within the focus person's community.

8. Focus persons should fully and actively participate in making the decisions that affect their lives.

9. Solutions to obstacles and issues that emerge during the person centered planning process are negotiated to ensure that resulting activities are consistent with the focus person's preferences and goals.

10. The focus person and family members partner with service providers and case managers to explore creative options to meet the preferences and goals expressed by the focus person.

11. Resources to support the focus person are based on identified needs that the focus person may have and are available in their community and in an agency. Natural resources presently available in the community are used first, then the agency resources. In instances where generic resources may not exist, they may need to be developed within the community.

12. All strategies and resources used must support the desired outcomes and identified needs of the focus person. Strategies are developed to increase the likelihood that individuals will increase control over their lives, participate in community life and develop relationships.

13. Person centered planning is a dynamic, rather than a static process. The support plan is revised as new opportunities and obstacles arise or when significant changes occur in the focus person's life.

14. A person's cultural background is acknowledged and valued in the planning and decision-making process.

IV. Difference Between Person Centered Planning and Traditional Planning

Person centered planning is an interactive planning process which brings together the people who live with the concerns and issues daily and who are committed to learning together to respond to the situation. Specifically, the differences are:

Traditional Planning	***Person Centered Planning***
A team of service providers meets annually with the focus person and/or family members to develop a plan for services	A person centered planning team made up of the focus person, legal authorized representative, family members, service providers and other community members meet as frequently as needed to develop and implement a future vision and goals for the focus person. The team will meet at least annually.
Relies on standardized and non-standardized tests and assessments.	Spends time getting to know the person.

Begins with an assessment process that highlights deficits. We look at the person in need of services and who has to get "ready" for community life.	A person centered planning team gathers, organizes, and manages assessment information into a personal profile and future vision and goals using highly visual and graphic maps.
The focus person and family members are invited to participate in the development of the individualized service plan.	The person centered planing team assists the focus person in a respected and competent manner to actively lead and/or participate in the meeting.
Establishes goals that are already part of existing programs. The plan is designed to fit the person into a particular program, even if that program is not exactly what the person needs.	The focus person, family members, friends, and general community members define the personal profile and future vision and look to service providers for supports.
Relies primarily or solely on professional judgement and decision-making.	Depends on people, families, friends, and direct service providers to build good descriptions.
An individualized plan is mandated to guide the services.	A future vision and action plan guide the activities and should drive the ISP content.
Implementation of the plan is ensured through provisions of professional services.	Implementation of the plan depends upon the commitment and partnership of the team and their connections with the focus person.

V. Tips To Support Effective Implementation of Person Centered Planning

A. Discovering the Person

1. ***Listen, acknowledge, and discover the personal goals, preferences, choices, and abilities of the focus person directing the plan****:*

a) A person centered planning process occurs only when the focus person is present.

b) Prior to the planning meeting, the facilitator goes over the issues to be discussed with the focus person or family/primary caregiver. They identify those issues that will be discussed in a larger group (public issues) and those that are to be discussed more privately (private issues).

c) The facilitator asks open-ended questions to elicit information from the focus person or family/primary caregiver in order to discover the preferences, choices, goals and abilities of the focus person.

d) The discovery process may or may not occur in a planning meeting with a large group of people. It can occur separately with the focus person, family/primary caregiver and those that know him/her well.

e) The discovery process solicits information based on the focus person strengths, capacities, gifts, skills, talents, and contributions.

f) All the information collected from team members (within or outside of the person directed planning meeting) during the discovery process must be confirmed with the focus person to ensure accuracy before documenting it.

g) The focus person's goals and preferences are constantly evolving; therefore, person centered planning is ongoing and not a one time/annual planning process. Question-asking, listening and discovering the preferences of the focus person is on-going.

h) Every effort must be made to ensure that the focus person is fully informed to make responsible choices.

2. <u>Documentation of the information gathered during a person centered planning process is important</u>

a) All information should be written in a respectful manner.

b) Document all the information gathered from the focus person /family to ensure that it is available to all pertinent staff and/or providers (new and old). This helps reduce or eliminate the need to ask the same questions repeatedly by new staff to the focus person or family members.

c) All the information must be documented in the plan without changing the meaning that the focus person/family attributes to it.

d) The documentation should cover the focus person's daily routines and desired goals. It should be descriptive, but concise, painting a picture of the focus person. Describing issues functionally provides a better picture of the focus person's need for support. For example, when documenting a behavior such as verbal or physical aggression, a description of how it manifests and the situations in which it occurs must be included. Merely stating that the focus person is verbally or physically aggressive may not provide sufficient information to determine the supports the focus person may need. <u>Example</u>: Tom often grasps his hands and breathes heavily prior to becoming physically aggressive by hitting or pushing people near him.

e) The person centered planning process must include information relevant to any issues concerning the focus person's health and safety. Supports to maintain the focus person's health and safety should be developed within the context of his or her preferred lifestyle so that it does not conflict with his/her preferences.

3. <u>The focus person determines who is involved in the planning process</u>:

a) The focus person chooses the members of the person centered planning team. The team may include family members, friends, and paid staff.

b) The team members must respect, trust, and support the focus person.

c) If bringing together a team for the planning process is difficult, then developing one should become a priority. However, the planning process can be initiated while the team is being developed.

d) The team members meet in a comfortable location, as defined by the focus person. This may help the focus person feel relaxed and open enough to share things that are important to him/her with the rest of the team.

4. <u>Identify the existing supports (natural or paid), both used and unused, that are consistent with the focus person achieving identified goals</u>

a) In most situations family members, friends, and the focus person have the most knowledge about the preferences, capacities, and gifts of their children, friends, and themselves respectively. However, professionals usually have knowledge of resources available in order to provide appropriate supports and services for the focus person. All members should play an active and collaborative role in order for the planning process to be effective.

b) The focus person, families and professionals recognize and document in the support plan the existing supports in the focus person's life.

c) Previously unexplored natural supports in the community are discovered during the process.

d) Identified supports match the preferences of the focus person.

e) The planning process considers the supports that the focus person may require for issues that may not be directly related to the outcome but influence the strategies and actions that are developed to achieve the outcome. For example, counseling for anger or stress management.

5. <u>Other professionals not originally included by the focus person in their planning teams are identified as consultants, when needed</u>.

a) All professional consultations, such as with a nurse or psychologist, occur in the presence, or with the permission, of the focus person/LAR and are conducted in a manner respectful to the focus person.

b) The person centered planning process team (i.e., focus person, family and professionals) and other professional consultants are encouraged to have a trusting and collaborative relationship.

6. <u>Issues of safety, health, rights, and freedom from abuse, neglect and exploitation are dealt with in the person directed plan</u>

The planning process includes a discussion of individualized health and safety issues in the context of the life desired by the focus person. The process maintains a balance between rights (choice/control), responsibilities and risks (health/safety) experienced by all citizens.

B. <u>Action Plan</u>

1. *To identify additional natural supports and negotiate needed service system supports*

a) Negotiate both natural and system supports to develop the best possible support plan to achieve what is important to the focus person.

b) The focus person determines his/her own supports by participating in selecting, evaluating, and when necessary, changing his/her activities and support staff.

c) The person centered planning process team members identify opportunities and activities to connect the focus person to the community.

2. *Implementation of the support strategies becomes the responsibility of the planning participants*

a) The plan of action includes i) goals and strategies, ii) person/s responsible for the completion of the goal and strategy, and iii) the date by which it is to be completed. The monitoring process is facilitated by including specific names of people and dates.

b) The goals and aspirations are prioritized by the focus person.

c) The most important goals and aspirations are addressed first.

d) A support plan is more easily implemented if the team works on a few goals and aspirations at a time.

e) The focus person is supported to develop community connections.

f) Preferences should not be considered to be the same as services and supports. Services and supports are used to facilitate the acquisition of the focus person's preferences. For example, the focus person may express a preference to work in a bank. However, he or she may require the support of a job coach to achieve the desired goal. The support of a job coach is not the expressed preference of the individual in this case. The job coach is the support needed to achieve a goal based on the expressed preference.

g) In a case where there is a disagreement between the individual and their LAR, every effort should be made to negotiate and clarify conflicting issues. The facilitator must keep the focus person's preferences and desires the main focus of the planning process and resolve the LAR's concerns to come up with the best compromise between the two.

h) There must be a partnership between all the team members to implement the support plan. No single team member should be responsible for its implementation.

3. *When people choose outcomes that conflict with state/programmatic standards, the following strategies should be considered to meet people's needs*

a) Identify goals/needs that can be achieved within the existing standards, rules and regulations within the DDARS system, while problem solving on how to accomplish the ones that are more difficult to achieve.

b) Explore resources in other systems and programs serving people with disabilities and services available to all citizens, whether or not they have a disability, in the community to fulfill these needs.

c) Use the existing system to its fullest potential and negotiate to create the best possible arrangement for the focus person.

d) Discover why a particular choice or the refusal of an alternative presented in place of the original choice is important to the focus person.

V. The Role of the Facilitator

One of the key elements of the person centered planning process is a good facilitator. A good facilitator doesn't just run a meeting, they must get to know and understand the focus person and significant others in that person's life. A skilled facilitator is one that clearly understands the change process and the corresponding values. Skillful facilitators have the ability to listen, concentrate, take directions from the focus person, and be inquisitive to constantly search for capacities and areas for exploration.

A number of people can serve as a facilitator during the person centered planning process. No one person is excluded from being a facilitator, and no person is assumed to serve as the facilitator. However, whoever serves as the facilitator must be trained and participate in a person centered planning process facilitated by someone else. See Appendix A for considerations in choosing facilitators for the person centered planning process.

VI. Monitoring the Quality of the Person Centered Planning Process

The quality of a person centered planning process is defined by the focus person and is reflected in more personal outcomes being achieved. There will be a multi-level monitoring process to ensure the quality of person centered plans. This section summarizes the indicators of successful implementation of person centered planning.

1. Evidence that the focus person determines his/her preferences during the person centered planning process with the support of family/LAR, friends, and staff if necessary.

2. Evidence that the focus person chose whether or not other persons should be involved and identified the people to be included in the person centered planning process.

3. Evidence that the focus person chose the time and location of the person centered planning session.

4. Evidence that the focus person chose their outcomes and support staff whenever possible.

5. Evidence that the focus person's preferences and outcomes were seriously considered and in situations where it was difficult to implement his/her preferences and outcomes, the team arrived at a compromise acceptable to all.

6. Evidence that case managers/service coordinators ensure that support plans remain current at all times and are monitored on an ongoing basis for their effectiveness in achieving the outcomes identified by the focus person with the support of their family/LAR. This is a critical element since a focus person's goals and preferences

are constantly evolving. It is important to keep asking questions, listening and discovering the preferences of the focus person.

7. Quality improvement plans actively seek feedback from the focus persons and families receiving services and supports regarding the opportunities they have to express needs and preferences and the ability to make choices.

The Person Centered Planning Process Happens When . . .

people work together to solve the challenges that arise
when individuals live and work where
and how they choose and strive to
reach their dreams and goals.

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